



# Arkansas Access To Recovery

## Understanding My Choices as an ATR Client

\_\_\_\_\_  
(Individual's Name)

\_\_\_\_\_  
(Individual's Address)

Arkansas' [ATR project](#) is based on the following principles:

- Individuals with substance use disorders and their families have the right to choose recovery and the recovery-related services and supports that best meet their needs.
- The service system should honor clients needs and beliefs, including their spiritual and cultural needs as well as their family situation and practical concerns
- Participation in AR ATR is voluntary and clients can end their participation at any time, without negative consequences.

As an ATR client, we want to make sure that you understand your rights and the choices that are available to you. Your care coordinator should explain these rights to you. Please initial the lines below to indicate that you understand these rights.

\_\_\_\_ I understand that participation in Arkansas Access to Recovery is voluntary.

\_\_\_\_ I understand that every community has at least 2 care coordinators and I get to choose who my care coordinator will be. I can also change my choice of care coordinators at any time.

\_\_\_\_ I understand that I get to choose the treatment and recovery support services that I need for me and my family.

\_\_\_\_ I understand that I get to choose who provides the treatment and recovery support services that I need. I understand that I may change providers and services as my needs change.

I have \_\_\_\_ or have not \_\_\_\_ been informed of the services which are available to me in my community through the ATR Program and I understand my options.

I have been given the attached list of ATR Certified Care Coordinators and Service Providers for \_\_\_\_\_ county. From that list, I am choosing:

\_\_\_\_\_ to provide my Care Coordination Services and  
(Fill in name of the chosen Care Coordination person/agency)

\_\_\_\_\_ to provide my treatment and recovery services.  
(Fill in name of chosen treatment and recovery services provider(s))

This decision does \_\_\_\_ does not \_\_\_\_ represent a change in provider(s).

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

If you would like to change your care coordinator, please contact Peggy Miller [by email at ppmiller@uams.edu](mailto:ppmiller@uams.edu) or at 501-682-9900. To change providers or choices of treatment, please contact your care coordinator.